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STABAT MATER SPECIOSA

By the crib wherein reposing,
With His eyes in slumber closing,
Lay serene her Infant-boy,
Stood the beauteous Mother feeling
Bliss that could not bear concealing,
So her face o'erflowed with joy.

O'er that lowly manger winging,
Joyful hosts from heaven were singing
Canticles of holy praise;
While the old man and the maiden,
Speaking naught, with hearts o'erladen,
Pondered on God's wondrous ways.

All who in the crib revere Him,
Like the shepherds watching near Him,
Will attend Him through the night,
By thy powerful prayers protected,
Grant, O Queen, that His elected
May behold heaven's moving light.

Let me bear Him in my bosom,
Lord of life, and never lose Him,
Since His birth doth death subdue.
Let me show forth how immense is
The effect on all my senses
Of a union so divine.

(Photo of a wood carving by H. Ludwig, a Tyrolese artist.)

"There Was No Room for Them in the Inn" (Luke XI, 7)

Christmas Thoughts

Nineteen hundred and thirty-six years ago! A starlit night; rich and poor flocking to Bethlehem to be enrolled in the census! A crowded Oriental city! The inns full to the brim! A humble carpenter and his spouse seeking shelter! In vain; for they are poor and strangers! But they must find an abode! They go on wearily until they come to a cave outside the city. As they enter, the warm breath of an ox and an ass take away the unfriendly wintry chill and, the great hour being near, they stay. In this isolation, in this poverty, the Son of God is born! The Mother lovingly wraps the Infant in swaddling clothes and lays Him in the manger.

Angel choirs chant "Gloria in Excelsis Deo!" But only shepherds tending their flocks nearby hear their jubilant song. The rest know nothing of the distant strains of these angelic choristers. For want of hospitality they miss knowing that the Desired of Nations is in their midst! Ah, if we had had their opportunity of ministering unto Him! Alas! We live nineteen centuries too late! Do we?

"What you do to the least of these, you do it unto Me." Is it true that we may still open our gates to Him, that we may still give Him bodily sustenance, may still warm His little body, may soothe His pains! Yes, it is verily true! What we do to others for love of Him, He accepts as done unto Him!

At Christmas, our friends and benefactors will have the joy of knowing that what they have done to "the least of these" for love of Him, they have done unto Him. Through their generosity, many have been given shelter, food, health, and happiness and, what is more, the Bread of Life! The day will come when they will realize more fully what it means to have received Him, to have ministered unto Him.

Our Christmas Wish is that our benefactors who help us for love of Him may enjoy the brightest of rewards

in saecula saeculorum.

WHAT PRICE MOTHERHOOD IN THE MISSIONS?

By Helen Lalinsky, S.C.M.M., M.D.

Today when extensive propaganda is being used to reduce the infant and maternal mortality in western countries it is not out of place to consider the same problem in mission lands. Even here in America, where doctors and nurses and medical facilities abound, there is room for improvement in maternity and child welfare according to current medical and public opinion. What then must conditions be in the missions generally where trained midwives are still the exception rather than the rule, and physicians, even in the capacity of consultants, are indeed a rarity, especially in the villages where reside from 80 per cent to 90 per cent of the inhabitants?

The average expectancy of life in mission lands is very low, for example, in India, it is only 23.2 for men and 22.8 for women.[1] Why? Because of the high infant mortality. This ruthless slaughter of innocents is due largely to preventable causes.

To a woman physician, Dr. Helen Putnam, of Providence, is given the honor of having taken the first step in the right direction in this country at the beginning of the century, when she insisted upon a committee being appointed to investigate our terrific infant mortality. As a result of this investigation which began with the first committee meeting in 1909, a nation-wide movement followed to educate the public, particularly the mothers. As a consequence infant mortality fell in less than two score years from 175-200 to 58 in 1934. Education of the citizens in regard to preventive measures cannot be underestimated, for public opinion wields a powerful sway.

During the last 10 to 15 years efforts have become more organized in the missions in this particular line of scientific endeavor. These have been made by women physicians in connection with mission hospitals, and various governments, and lay organizations.

In studying conditions which exist in non-Christian lands, the average reader has found much emphasis laid upon tropical diseases

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[1] *Indian Year Book for* 1934-35, Vol. xxi, page 977.

and has been duly impressed with such fascinating names as *kala-azar*, beri-beri, trypanosomiasis, elephantiasis, yellow fever, and a lengthy array of others. How often has the importance of maternity and child welfare been stressed? Certainly not until very recent years. Subsidies from governments are granted only reluctantly if at all. Dr. Ruth Young, Director of the Indian Red Cross, remarks on this state of affairs: "One is forced to a monotonous repetition of the statement that progress is very slow, that local bodies and even provincial governments evince little interest in the work and have no convictions about it sufficient to prompt them to spend money on such a subject."

Apropos of this subject, the Sacred Congregation of Propaganda Fide issued an Instruction on February 11, 1936, to religious institutes of women regarding the assistance of mothers and infants in missionary lands. Quoting in part:

"It has always been the practice of this Sacred Congregation to have the methods of the apostolate conform to the varying needs of time and place. Several missionary Ordinaries have brought to the attention of the Holy See the necessity of making more appropriate provision for the health of mothers and infants. *In some regions of Africa tribes are decreasing day by day and they are destined to disappear if provision is not made for a better assistance for mothers and infants.** It is well known that in other lands infant mortality is appalling, owing to the want of hygiene.

"The governments of those countries are taking an interest in this problem, and non-Catholic sects are giving great attention to it. Some governments demand that nurses obtain a special diploma before permitting them to engage in this work in hospitals.

"Various private undertakings have already been started for the care of mothers and infants in missionary lands; these efforts must be regulated and coordinated.

"This Sacred Congregation has studied the question at length, and, after obtaining certain necessary faculties from the Holy Father, acting in accord with the Sacred Congregation for Religious, believes it opportune to issue the following rules and instructions:

"1. This Sacred Congregation would like to see new religious institutes for women founded who will dedicate themselves principally to health work. . . .

"2. This Sacred Congregation will likewise be pleased to see

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* Italics are ours.

already existing religious congregations of women start special branches for the work mentioned above. . . .

"These duties demand a proper technical and spiritual preparation. The sisters should obtain certificates as doctors and nurses. . . ."

Prevention is the primary object of the maternity and child welfare movement. The very fountain-head of the trouble must be sought and eradicated. Factors influencing the death rates include apathy of the general populace in regard to hygienic habits, ignorance, illiteracy, extreme poverty, prevalence of superstitions, witchcraft, religious fatalistic convictions, overcrowded dwellings, inadequate diets, injudicious use of opium. Unsanitary conditions provide an abundance of breeding places and camping grounds for numerous diseases. All these factors must be attacked deliberately and systematically before any progress can be made.

At the All-India Conference of Medical Research Workers in 1926, a resolution was passed which aptly describes conditions that are found there: "This Conference believes that the average number of deaths resulting every year from preventable disease is about 5,000,000 or 6,000,000 . . . and that the percentage of infants born in India who reach a wage-earning age is about 50, whereas it is quite possible to raise this percentage to 80 or 90. The Conference believes that these estimates are understatements rather than exaggerations. . . ."

The task of raising the health standards in these countries falls in a large measure to women. Medical and social problems raised by such institutions as *purdah* and early marriage have attracted wide interest. For various reasons, but chiefly because of the nature of the work, and the seclusion of women in some mission countries, women physicians are preferred. In India about 40,000,000 women observe seclusion, or *purdah,* and are not permitted to be seen by men other than those of their own household. This necessitates medical attendance by women or the alternative—no attendance at all. Some patients have preferred to die undelivered than be delivered by men. Others will consent to see men doctors only if they are in danger. This *purdah* is a recognized principle of Mohammedanism and has existed since the eleventh century. The measure was used originally to protect the women against invaders. It was also adopted by many Hindus and has survived these ten centuries. The veil is being gradually lifted in India. *Purdah* does not exist as such in Egypt, Persia and Palestine, but attendance by women is preferred, as is also the case in Africa.

The comprehensive "Report on the Role of Medical Women in Exotic Countries," by Dr. Margaret I. Balfour,[2] gives first-hand information from physicians on the mission fields. Dr. E. Whidhorne writes from Sudan, Africa: "The woman of the Northern Sudan is a lady of large dimensions, whose ambitions in life are to be fat and to bear children. She begins life as an adorable baby and becomes a slim and attractive, graceful, small girl with beautiful manners. At the age of 10 . . . the tribal marks are cut on her face with a razor. A short time later she becomes *hareem* and is a prisoner within the four walls of the mud compound. She is now being fattened and prepared for marriage, which with luck, takes place at 15 or 16. From 20 to 30 she is so busy bringing children into the world, that she does not have time to look after those already belonging to her. Soon after 30 she becomes a grandmother and as such she takes over charge of her daughter's children, whom she looks after well, according to her lights. . . . Not only is there an appalling waste of infant life and health as a result, but also, there is an equally appalling waste of womanhood."

In the same survey Dr. Balfour quotes Dr. S. G. A. Henriquez who reveals conditons existing in Persia—the same being found in India: "It is a great mistake to believe that Persian girls mature early, they do not do so at first. Certainly a girl of 17 may look as old as an English girl of 25, but that is because she may have had two or three children. The 12-year-old child is often a little, undeveloped creature; she has left school on her marriage at the age of 9, consequently she is very ignorant. She leads a very sedentary life, does not know how to play games. . . ."

Debility of both mothers and babies naturally follows such customs. So we see that for our less fortunate sisters in mission lands life is certainly not a bed of roses. In passing it may be interesting to remind our readers that one of the seven wonders of the world is dedicated to the victim of childbirth. That exquisite rhapsody of architecture, the Taj Mahal, in Agra, India, stands a silent monument, erected by Shahjehan, to the memory of his wife, Mumtaz Mahal, who died at the age of 39 when her fourteenth child was born.

In the missions generally, the paucity of registration data has made it well nigh impossible to calculate birth and death rates ac-

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[2] Presented at the Convention of the Medical Women's International Association in Vienna, September 15-20, 1931.

curately because illiteracy prevails and only a few governments have registration laws and fewer still enforce them. In Singapore birth certificates must be presented before entrance to schools; this is conducive to better registration. In Tanganyika, Africa, the government has resorted to a unique method of census taking. Balls of colored string are provided for the villagers, each ball representing a certain age and class. As the people of the village pass by the headmen, a knot is tied on the ball of string representing that particular age, group or class.

In Chinese [3] villages the registration forms are supposed to be explained to the people, after which it is incumbent upon them to report births and deaths. They are given a few sheets of paper and tested for the number of common names they can write. Chinese names of infectious diseases are not included in the "Thousand Characters" so in recording deaths they must resort to such simple terminology as: "Four to Six Day Wind" indicating *tetanus neonatorum*, "Heavenly Flowers" for small pox, "White Throat" for diphtheria, etc.

Maternal deaths are largely due to preventable causes. This statement is true of any part of the world. With the institution of proper prenatal, natal and post-natal care, the rates fall dramatically and the number of helpless women sentenced to face a life of misery in chronic invalidism, which frequently follows injudicious treatment, is proportionately reduced. Maternal mortality rates in exotic countries must necessarily be considered with a grain of salt. The Murshidabad (India) investigation showed that maternal deaths averaged over 100,000 annually in India alone. The following are rates of maternal mortality per 10,000 live births:

1926	Calcutta	380	1933	Netherlands	32
1933	Madras	135		Norway	28
1933	Chile	84		Canada	50
	Japan	36	1934	United States	59

The following description of an actual delivery in Nyasaland serves for other mission countries as well: "The woman is separated from her family and put into a hut, with the filthiest of rags for clothing and nothing that has any claim to cleanliness is allowed to touch her. Soap and water are unknown quantities. Then she is not given any food from the beginning of labor until after delivery, with

[3] C. C. Ch'en, M.D., "Scientific Medicine as Applied in Ting Hsien."

the result that a prolonged labor results in the mother being doubly exhausted. Naturally this causes much maternal mortality. . . . Any old rag is used to wrap the newborn babe in, often with resulting tetanus and septicaemia. . . ."

In West Africa if the child is not delivered in a reasonably normal time, the women are beaten and cruelly treated. If there is any abnormality, they die. Anesthesia or even analgesia are out of the question.

In addition to general systemic diseases which exist in Western countries, the prevalence of tropical diseases with the resultant severe anemias, venereal diseases, nutritional diseases as beri-beri, rickets and osteomalacia are frequent. Rice-eating is widespread; inadequate protein and mineral intake, and likewise a minimum of vitamins is therefore furnished. As a result of the fairly common disorder, osteomalacia, the bones become softened and deformed producing pelvic contractions with consequent difficult or impossible delivery. Such cases necessitate Caesarian sections, but because of lack of medical help, the patients not infrequently die undelivered. It is said that they may linger on for 11 days before death relieves them of their frightful suffering, the untrained *dhai* meanwhile exerting all her powers by kneeling on the abdomen, branding the woman with hot irons, etc. Pelvic contractions may be the result of protracted rickets in childhood. The habit of heavy weight carrying on the heads of young girls predisposes to this complication also.

The most important single factor in the excessive maternal and infant mortality rates in mission lands is naturally the lack of skilled attendance at the time of confinement. The Indian *dhai,* the Malayan *dukun* and the African untrained midwife can all be placed in the same category. Until recently in the Chinese villages there was no such profession as midwifery. Even now any woman who has given birth to a few babies herself is qualified to deliver the babies of her younger neighbors. A half dozen or so, for various reasons, distinguish themselves in "operative skill" and handle more cases than others. These women deliver hundreds of thousands yearly with little or no conception of cleanliness. In parts of Africa there are no midwives, confinements taking place outside in the "bush" superintended by a relative.

A missionary priest writing from Africa gives his account of a poignant experience: "In some tribes the future mothers are in confinement in roughly made huts, in others the children are born in the

open air. In all cases the patients are naked on the bare ground. Think of how many cases of infection followed by death are the result of these methods. I shall always remember a circumstance of my missionary life. I had been called by a poor Christian woman who had been recently abandoned by her husband. She was suffering from pneumonia, but was not at all in immediate danger. I gave her the Sacrament of Penance and promised to give her Holy Communion the next morning. I did not know that she was pregnant. The next day when I came back, I found her lying on the ground alone with a beautiful, little newborn baby boy. He was nestling close to his mother and wailing pitifully. I had never realized that there could be such destitution and could not help but cry myself. The mother was very weak but conscious. I covered her with some cloth found there and gave her Holy Viaticum. Suddenly the poor creature fainted and died in my arms. On the spot I baptized the little boy who had come just in time to be saved for eternity. I am certain to this day that the mother and child were buried together, but I am not at all certain that the two were dead before burial."

A traditional, jealously guarded method of midwifery still exists in India. Thousands of untrained, uneducated *dhais,* unclean in their habits, well-meaning but oft-times brutal in their methods, persistently and tenaciously adhere to their old habits. Lamentable ignorance among this class is common; asepsis is practically unheard of, or what is often worse, laughed to scorn, and mortality statistics are simply appalling. What a vast amount of preventable suffering and misery, what a toll of lives lies at their door, can be judged in some measure by those who with their own eyes have seen the devastating consequences of the *dhais'* incompetence. Lives of numberless babes and mothers have been sacrificed on the altar of ignorance. Many qualified physicians practising in the missions trace series of infections to the same careless midwife who does not believe in washing her hands and much less in the use of that disinfecting agent par excellence, soap. How many more doctors have been called in only after the harm had been done, and the midwife, like the hireling she was, had fled!

Parturient women the world over need constant, skilled supervision even if healthy. How much more is it needed when pathological conditions arise? Yet normal conditions are frequently interfered with and abnormal ones not recognized by these quack midwives. To disprove the old adage, practice does *not* make perfect in these cases, but only ingrains gross errors deeper and deeper into

their systems. Suppose native women were properly trained in the theory and practice of midwifery, with adequate supervision, it would be only a matter of a comparatively short time before they would become very proficient, there being no dearth of experience to hamper them.

In *India in* 1930-31 we read: "That adequate medical aid should be provided for Indian women at the time of childbirth—particularly in the rural parts of the country, which contain about 90 per cent of the population—is obviously a matter of immense importance; but it is also, in view of the illiteracy, superstition, and uncleanly habits of the ordinary *dhai,* and the degrading and menial tasks which her clients are accustomed to require her to perform, extraordinarily difficult. So hopeless, indeed, has the task of raising the *dhais'* standards of work to a tolerable level appeared to some authorities, that they have until recently advocated abandoning the attempt altogether. Against this, however, is the fact that educated women who have received training in modern methods of midwifery can hardly earn a decent living in the villages without some form of subsidy. . . . Thus, from the very nature of things, improvement in the methods of maternity work in rural India, either by means of training and educating the *dhais,* or by endeavoring to acquire the services of women of a different type, is bound to be a very gradual and apparently disappointing process. . . ."

In the India Year Book for 1935, Dr. Ruth Young, in speaking of conditions that exist in the Madras Presidency states that trained health workers are almost absent and that the number of midwives available is about one for every 1,300 cases of childbirth *per annum* and that only one qualified medical woman is available as *consultant* in one out of every 7,000 labor cases! This ratio is even worse in other parts of the missions, for instance China because the majority of physicians practise in the large cities along the sea coast.

Medical men on the field have given and continue to give lectures to student midwives but because of the general preference for women doctors, the necessary follow-up of after practise is lacking to the detriment of the patients and the midwives. The number of medical women on the field who can spare time to carry on this important work is small.

Where supervision and training of midwives has been started, the results are gratifying and convincing. "With statistics, you can prove anything, even the truth," once remarked a prominent surgeon.

Comparisons of maternal and infant mortality rates among trained midwives and untrained *dhais,* speak for themselves. In the city of Dacca, Bengal, India, two trained sisters of the Society of Catholic Medical Misisonaries act as Health Visitors for the city and conduct two maternity and child welfare centers, also supervising the work of midwives. During the year 1935, these two centers attended 1,467 cases during confinement. A comparison of rates between center and non-center rates is given below:

	Center Cases	Non-Center Cases
Maternal mortality.....	4.09 per 1,000	9.9 per 1,000
Infant mortality (within 10 days of birth) 36.1	per 1,000	66.2 per 1,000

Both maternal and infant mortality were cut in half. If such results can be accomplished in a short time in a localized area with limited personnel, how much more could be done if more workers were available?

As already mentioned, maternity and child welfare work sprouted as an off-shoot of mission hospital activities. In some cases lay organizations sponsored the work. The Protestants have done admirable work in this field as in medical missions generally. In Africa and India there are areas where midwives are trained in connection with hospitals. Funds have been established for the training of indigenous *dhais,* provinces have passed legislation governing their training and practise but these have not yet been enforced, except in a few places, for example, Malaya. In the Dutch East Indies their training but not the after practise is regulated. Neither does Hongkong enforce the law on this question.

In China, since the founding of the Ministry of Health in 1928, rapid strides are being taken in this phase of work. A National Midwifery Board was organized in 1929, and the Peiping School of Midwifery was founded the same year. The latter has under its direct supervision 286 old type and 50 modern type midwives. Another school was opened in Nanking in 1933. China's aim is to train 100,000 competent midwives during the next 50 years. A splendid goal!

"One of our priests," says Father Cremonesi, of Tougon, "has observed after visiting the missions of the Milan Foreign Missionaries in China and India, that one family converted to the faith in China

becomes a village in 50 years' time, but in Burma a converted village is reduced to one family in 50 years.[4]

Infant mortality is "the price of adaptation paid by each generation when entering life, as the settlement of a new country takes its toll from its immigrants." [5]

Let us compare the League of Nations infant mortality rates per 1,000 births in several large cities throughout the world for 1934:

Alexandria	213	Oslo	21
Amsterdam	34	Port Said	194
Manila	139	Singapore	179
Nagasaki	70	Tokyo	120
New York	52	Tunis	159
Bombay	245	Calcutta	260

In the statistical bulletin for Hongkong for 1934, an infant mortality rate of 347 is given. This figure cannot be relied upon. Supposing that only one-third of the births are registered, the mortality rate would still be high. The occurrence of a birth is apt to be much less noticed than a death; this tends to vitiate statistics. In Shanghai the number of children that die under one year equals 12 per cent of the total deaths. Japan has always had a low infant mortality rate in comparison with other Asiatic countries.

The 1933 report of the Public Health Commissioner of India gives the following data:

Population, men	140,000,000
Population, women	132,000,000
Births	9,678,876
Infants' deaths	1,650,973—27% of total deaths
Total deaths	6,096,787
Infant mortality rate	170.5 per 1,000 births

Almost 5,000 babies die daily in India. There the infant mortality is about seven times that of the adult mortality, about three times that of England or the United States, more than double that of Germany, and five times that of New Zealand and the Netherlands. The urban rates are much higher than rural rates. In the city of Bombay for 1934 the rate was 245.93 for 1,000 births; in Yeola and Poona, Bombay Presidency, the rates were 573.64 and 387 respectively. Rural

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[4] "Infant Mortality in Burma," THE MEDICAL MISSIONARY, Vol. IV, No. 4, p. 13.

[5] "The Perilous Threshold of Life," K. Stouman, former Chief Statistician of Health Section of League of Nations Secretariat.

rates approached 200 in this province, in Dadu the rate was 83.95, the lowest found. Comparing the years 1933 and 1934, the rates were increased in all the provinces of India except Bengal and the Punjab.

The causes of this great outlay are legion. Difficult childbirth, general debility, prematurity, respiratory disease, dysenteries, infectious fevers, tetanus, beri-beri, scurvy, rickets, etc. In the Bombay district, general debility, respiratory affections and prematurity accounted for 77 per cent of infant deaths. Nine hundred and twenty-four infants died of beri-beri in the first year of life in Tokyo during 1933. Malaria is frequently the cause for severe anemias. Tetanus occurs in China, Africa and India because of frequent deliveries on the floor or ground and the use of dirty cloths to encircle the child. During 1927 the toll taken by tetanus in Calcutta was 476 infants. The care of infants and their isolation from tuberculous and leprous mothers is a problem in itself.

One-third to one-half or even more of the babies die in the first few weeks of life because of neglect, ignorance, and lack of proper feeding. Digestive disturbances are very common and not surprising. In Burma the natives feed the newborn babes rice on the fifteenth day. Where artificial feeding must be employed milk is frequently from questionable sources; bottles and nipples are deplorably prepared. The premature babies, already handicapped have an additional struggle for existence, even with the best of care in hospitals where a maintenance of body temperature may be easily maintained, where isolation to prevent infection, and adequate feedings are assured. They simply have no chance in the homes.

Dr. Anna Dengel [6] comments about babies in India: "In many places in India, the newborn baby is not clothed but only wrapped in a rag or a shawl and put under the mother's comforter to keep it warm. Needless to say it does not get fresh air in this way. Readers may think that this is a matter of poverty, but by no means is this the case always. On one occasion I had to attend a rich Hindu lady who was extremely happy to have a son and heir. He was wrapped in a soft shawl but no other clothes were put on him. Being December and the weather being quite cold, I advised that he should have a little garment on account of the frequent exposure. Then I was enlightened on the reason of this mode of procedure. The mother said that she had already lost two children who presumably were taken

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[6] "The Suffering of Children in Non-Christian Lands," THE MEDICAL MISSIONARY, Vol. IV, No. 4, p. 4.

away by evil spirits. To avert the same fate, this one was offered to the gods as a *yogi,* or holy beggar, and as such was deprived of the comfort of clothes." The relatives heeded her advice and "to my delight, the next day I found my little beggar . . . dressed in a quaint little garment made of 14 pieces of silk of various flashy colors, red, green, blue, purple, yellow, etc. The idea was to imitate the patched rags of a beggar."

A bishop describes conditions which exist in his vicariate in British East Africa: "Not infrequently, the first-born dies, because of the inexperience of the mother, who generally marries shortly after puberty. Usually, the children die at the rate of one out of every three. This is due principally to malnutrition, and also the fact that they are not properly clothed. Pneumonia sets in, and the result is fatal. Many of the mothers allow the children to eat anything, anytime, and anywhere. . . . These African mothers most certainly do love their young ones; their apparent neglect of their young is due chiefly to ignorance."

In the *Indian Ladies Magazine,*[7] Dr. Baliga writes: "I would suggest that rate-payers in every municipality should compel the municipal authorities to hang up in the council hall monthly returns, in large type, of deaths and births and infant mortality figures so that when the council meets every month, the city fathers may know what real steps they have taken to increase the happiness of the people by lowering the death rate among the general population and what attention they are paying to the babies entrusted to their care."

Knowledge must be made to penetrate into the highways and byways. To establish training schools for indigenous midwives, to organize maternity and child welfare centers, to open milk-kitchens, nursery schools, to educate women in simple hygiene, rudiments of mothercraft, nutrition and dietetics, thousands of trained workers are needed.

Eleven years ago the Society of Catholic Medical Missionaries was founded by Dr. Anna Dengel for this very purpose. As mentioned earlier in this article, the field has been opened by the Church this year to all missionary sisters. It can be safely predicted that this work will soon show results in the saving of innumerable lives of mothers and children and what is also important, in preventing

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[7] "Infant Mortality in India," Vol. IV, No. 5, Dec., '30, p. 272.

that prolonged agony of chronic suffering which is today the fate of so many because they have not proper care at the proper time.

Archbishop Arthur Hinsley, the successor to the late Cardinal Bourne in the See of Westminster, wrote while Apostolic Visitor to Africa: "The great opportunity of the Church lies especially in the rescue of womanhood. . . . Here we have our power. No others, no Government, not the sects, can wield the heroic might of our vowed and consecrated sisterhoods. . . . Moreover the heads of our missions recognize the absolute necessity of having a staff of missionaries, particularly of sisters, who can help to stem by skilled care and scientific methods the awful ravages of disease among the African people."

As the Sacred Congregation of Propaganda Fide has expressed it, none can fail "to see a noble expression of Christian charity in this delicate service, a charitable work destined to ease bodily misery and to open the way for the graces of the Redemption."

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The Society at Home and Abroad

WASHINGTON

My First Christmas at The Medical Mission House

December 18—just one week before Christmas. What was Christmas to be like this year—my first Christmas as a Medical Missionary—my first Christmas away from home and loved ones. Icy-cold shivers ran all over me every time I thought of it. There was, however, one consolation. Eight other companions were to share the same predicament. Fortunately, I was allowed few idle moments in which to muse over my sad plight (idlers just couldn't exist at the Medical Mission House). Each day was filled with lively preparations for the coming feast of Bethlehem's Babe.

Behind closed doors, three Sisters were busy putting the finishing touches to a crib which was to be a surprise on Christmas eve. Spicy aromas, drifting from the direction of the kitchen very forcibly suggested fruit cake and a variety of cookies. Sisters returning from the post office laden with packages and mail; a tree waiting to be decorated; poinsettas to be used in the chapel. Gradually the Yuletide spirit gripped me fast and firm and stamped out my icy forebodings.

Almost before I could realize it, it was Christmas eve. Early to bed, was the order! Suddenly "Silent Night, Holy Night" resounding through the mid-night air. Silently, we hastened to the chapel, a glow of red and green and gold; a little babe lying on a simple bed of straw; silence; peace; unspeakable joy; the procession under the clear, starry sky to the crib outside—a strikingly beautiful and realistic representation of the little cave of Bethlehem. Solemn words of the Martyrology uttered reverently in a deep voice by a deacon; Christmas carols, old yet ever new; then back to the chapel; Solemn High Mass; Gregorian Chant rendered with all its jubilant, joyous beauty.

Scarcely had the echo of the last prayer faded into silence before a chorus of "Merry Christmas" broke the stillness. Hearts bursting with joy! "Merry Christmas" expressed not only in English, but in German, Dutch, Irish, Hungarian. Beaming faces; true happiness; a table laden in gala holiday array; a few hours' sleep; Solemn High Mass in the Holy Cross Foreign Mission Seminary Chapel.

Santa Claus, in all his glory, passing out packages—big, little, round, square, tall, flat; letters and scores of cards; laughter, noisy chatter; joyous contentment. In the midst of it all, a call to dinner; masterpieces and surprises only cooks can produce; more laughter; more chatter; good will to all!

Then came the evening. Solemn Benediction; God's blessing over all mankind; silence; musings; no cold shivers, but a fervent thanksgiving to God. Never had I experienced a more genuinely happy or joyous Christmas tide!

Past and Future

We look back on this year as a very eventful one for us since it brought with it a great impetus to professional Medical Missions. The Sacred Congregation of Propaganda Fide, on February 11, issued an Instruction urging Sisters to study medicine and nursing so as to render professional medical aid to the sick in foreign mission lands. As we were founded for this specific purpose 11 years ago, and had anticipated this desire of the Sacred Congregation of Propaganda Fide, it brought joy to our hearts.

This year is also a milestone for us in that Dr. Helen Lalinsky, S.C.M.M., obtained her medical degree. Dr. Lalinsky made her complete pre-medical and medical studies as a member of the Society and is, as far as we know, the first to have made her entire course of medical studies as a Sister. Already a good-sized group is following in her footsteps.

While we have not multiplied, but rather strengthened our existing missions in India, we have one more Tabernacle, making five in all. Circumstances demanded that our Sisters in Dacca who do maternity and child-welfare work live in separate quarters, which made two chapels necessary.

The fact that our little pioneer band is increasing steadily is a great joy to us. However, we have completely outgrown our present quarters and have reached the stage where we must obtain a larger house. This requires a substantial sum of money.

A member of the American Hierarchy, seeing our great need, promptly gave us a generous gift for the first cornerstone. It is a great encouragement to us that this first donation came from a Shepherd of Souls. Now we need three more cornerstones and then the wherewithal to complete the building. As usual, this will require the cooperation and sacrifices of many.

All the Sisters at Home and in Our Houses in England and India Wish You a Peaceful Happy Christmas and a Blessed New Year

Our Hospital in Rawalpindi, India, Dedicated to the Holy Family

Mothers of

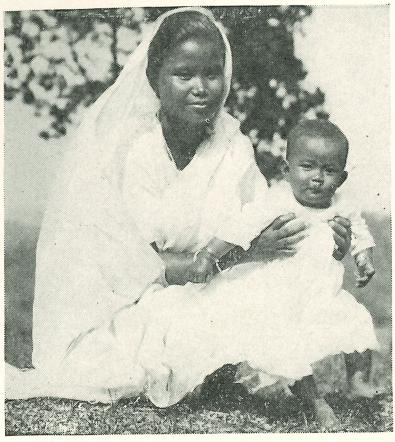
INDIA

JAPAN

JAVA

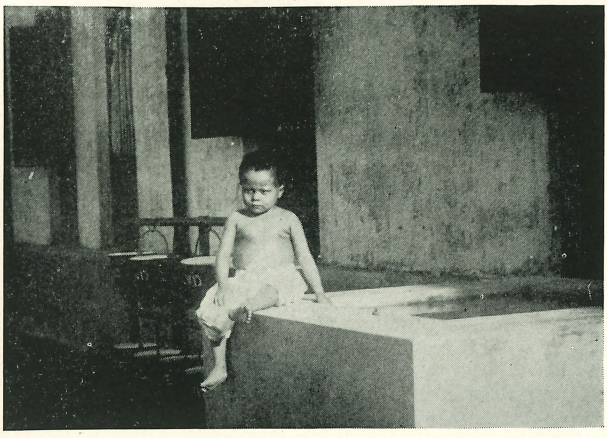
Many Lands

AFRICA



GAROLAND

CHINA



"Chini Sat There as a Silent, Immovable Buddha"

Our Sisters on Their Rounds From Hut to Hut in Bengal's Picturesque Villages

Although we are ending this year with the problem of suitable quarters for our Society confronting us like a mountain, we are confident that Divine Providence will come to our assistance if we do our share and that 1937 will bring us the much-needed accommodation.

DACCA

"Meet Chini"

Sister M. Teresa sends us the following account of the hospital's pet:

"Chini doa! Chini doa!" (give me sugar) sounded the mournful wail in the big hospital ward! But the little mite did not cry long because the sugar was promptly forthcoming. Apparently "spare the rod and spoil the child" is an unknown adage in India, for a child's least desire is law. However, in far too many cases the babies cry in vain even for milk, their one essential food.

The owner of this voice was "Chini," so called because of his insistent demands for sugar. He was a wizened little creature, probably 18 months or 2 years old. Nobody knew exactly. He had a big, rickety head, protruding abdomen, arms and legs like wooden sticks. His mother came to the hospital dying of kalaazar, a disease common in Bengal. She came too late to find health for her poor, tortured body; but in time to find the priceless gift of life eternal. Chini was an object of pity as he crouched beside the body of his dead mother. I can see him yet, crying as if his little heart would break, not realizing why his mother lay so still.

His father, upon being informed, came to remove the body, but left Chini at the hospital. He visited him a few days later, but we have not seen or heard from him since. No doubt he thought the little fellow would soon follow his mother.

The patients were very good to the motherless mite, carrying him about the ward and helping him to drink his milk and eat his *sugi* (Indian cereal). Chini soon responded to the loving care he received and grew quite cheerful. Before long he was eating his plate of curry and rice like a manly little fellow. If fish curry was served and Chini was given what he considered too small a portion, he refused to eat and sat there as a silent, immovable Buddha. The cook would then add to his portion and, Chini's injured feelings now soothed, he would assume his wonted smile.

Chini made many friends, especially among the medical students and nurses, who gave him candy, peanuts, toys and occasionally a sweater or *dhotie*. Some of his friends traveled as far away as sunny California, but did not forget our little Chini.

He would follow the doctors around the wards and return to explain to the other patients that this patient had fever, that one had to have an operation, and so on. During his four years' stay in the hospital he invented many amusing little games. His favorite one was "playing doctor," especially if he could find a victim for an operation or a hypodermic injection. He spoke Bengali well, having been taught by the nurses. He even managed to learn a few sentences in English, which he proudly produced on proper occasions. One day, when he had visited us in the nurses' home, he took his adieu by saying in perfect English, "Good-bye, dear."

While we were concerned with the welfare of Chini's body, we did not neglect his soul. One day, our motherless little charge was taken, not to our humble hospital chapel, but to the Cathedral itself, for baptism. Since then he has been adopted by a Catholic family in a distant village. He is dearly loved by his foster parents, but he still remembers and talks of his happy days at the hospital.

In the Limelight

We clipped the following from a letter received recently from one of our Sisters in Dacca:

"Since you are so often requesting, then begging and then again requesting movies of the work here on the field, we thought we'd see what we could do about it.

"When we were going to Rishipara (the Shoemaker Colony) last week, we invited Brother Walter, C.S.C., the official photographer of the diocese, to come along and see if he could get some movies while we were taking care of these poor people. A large group of men, women and children were waiting for us. We gave the usual treatments and medicines, then distributed free milk to about 20 babies, after we had weighed them. Someone had given us candy, which we took along for the youngsters. I tried to distribute it myself, but I nearly got mobbed, so the Rishi men did it for me. Brother Walter took the movies of the performance and I am sure the Rishis thoroughly enjoyed being before the camera. I hope the pictures come out all right, but if they don't I'm sure they won't object in the least to Brother 'shooting' them with the camera again.

"When we finished at the Shoemaker Colony we went to one of our small centers in the village. Upon our arrival the youngsters brought out their *bajnas* (musical instruments) and the little boys began to dance for us. They acted perfectly natural when they saw the camera. You may decide that they will do for Hollywood!

"The Bengal Women's Council gives us 36 rupees a month to help pay for some of the medicines, etc., that we use at the Center. Medicine is distributed twice a week to the women and children. We can't possibly accommodate the men also, but they come seeking help just the same. About 20 of the most undernourished babies receive milk daily. We have a sewing class for the young girls and women twice a week. The women usually bring along two or three babies so they don't make a great deal of progress in sewing, but the young girls are doing very well. Some of them make clothes for their baby brothers and sisters, and occasionally they get a dress done for themselves.

"Here at the Center we are not equipped to keep patients for hospitalization, but now and then we are forced to take one. Within recent weeks we have had three; two lost their husbands in the pox epidemic last spring and the third one's husband is insane and is roaming the streets.

"Usually the doctors care for these patients gratis, but we have to obtain money for their other expenses, as the Center Trust is unable to take care of them. A kind friend at home paid for one of them. May God bless her!

"The babies were given to the mission and we try to keep the mothers two months, as no one will employ them soon after confinement. Otherwise they would be forced to beg in order to exist. One of our former patients tried this and told us a harrowing tale of her experiences. It is no wonder that most of the professional beggars are a depraved, vicious lot. All employers do not turn away their unfortunate servants in this way, but some even see that they receive a bit of care."

Sister Helen, because of nurses' classes and examinations, had to delay taking her vacation until October. This year she went to quiet, peaceful Toomiliah and spent it with the Holy Cross Sisters. While there, she visited a few of the flourishing mission stations in another section of the Dacca Diocese.

"Several days ago," Sister writes, "Sister Augustine Marie and

I took a little trip to see the nearby missions. As usual, we went by country boat. It took us 14 hours to reach Golla, which is only 22 miles from Toomiliah. The next day we visited Bandhura and Hashnabad. In my opinion, Hashnabad has the nicest church in the entire diocese. The missionary settlement in Bandhura is a village in itself because so many buildings are grouped together. We visited the school while it was in session and were quite impressed with the efficient way in which it is conducted. Brother Andrew, C.S.C., who is in charge, told us that the daily average attendance is a thousand.

"We also visited Shalapur, where Father Hennessey, C.S.C., reigns supreme. He received us with real Irish hospitality. Father is pastor, sacristan, school mistress, nurse, cook, etc., etc. He is quite alone and a real missionary. Wherever he is stationed he opens a school for Indian girls, as he says the boys are well taken care of. The children love him and follow him everywhere. He tells the girls to be Sisters as, no doubt, he realizes the hard lot of married women in India. It is encouraging to see such flourishing activities as churches, orphanages, schools, etc., in other sections of the diocese, but hospitals are lacking."

RAWALPINDI

Along the Route

Sister M. Vincent and her five Irish companions just arrived in Rawalpandi. Let her tell you what they found interesting along the route: "After a visit to the famous mariner's shrine of Notre Dame de la Garde, at Marseilles, we returned to our boat. I saw a British destroyer close by and asked the other Sisters to go over and see it. A sailor approached us and inquired if any of us spoke English, since there were two English-speaking nuns on board who were fleeing from Spain in disguise. We were thrilled at the prospect of meeting Sisters who had lived through the terrors of persecution and escaped with their lives. We shook hands with them and asked a thousand questions about the rebellion. They told us that conditions were every bit as bad as our newspapers reported and daily growing worse.

"The Moldavia dropped anchor at Port Said at night so we did not see much there. Port Sudan, our next stop, was more interesting, as we arrived in the early afternoon. We could see the cross of the Catholic Church off in the distance and we tried to find it without receiving directions. But our travels seemed to get us nowhere.

Suddenly, we saw a native with a big stick under his arm, so we followed him. When we reached the Church he as suddenly disappeared. I am sure it was Saint Christopher!

"The church was locked. We knocked at the door of the priest's house and asked him if he would open it for us. It was Thursday and our only chance of making the Holy Hour in the presence of the Blessed Sacrament. Father kindly let us in and turned on the fan.

"While we were still praying he returned to the church, saying that the Sisters wanted to see us. After giving us a hearty welcome to Africa, they showed us the school and all the classrooms. The Sisters are "Pious Mothers of the Negroes," an Italian order. Only two of them spoke English.

"When we went up to the community quarters they were all sewing, so I joined them and turned down the hem of a tea cloth. The Sisters gave us an iced drink and then who should come in but the five French priests who were passengers on the boat with us. They were surprised when they saw that we had arrived before they, and especially when they learned that we had walked all the way.

"They did not remain long, as they wanted to see the native village, but said they would be back for Benediction at 5.30.

"We talked and talked, and the Sisters assured us we were a great help to their English. I think we were even a greater help to their larder, as we had more cold drinks and cookies before we left.

"The Benediction was really lovely. The French priests and the Irish Sisters sang to their hearts' content.

"While we were returning to the S.S. Moldavia in a rowboat all sang the *Ave Maris Stella.* It sounded inspiring across the water and I am sure it was heard on the other side.

"Here we are in Pindi. We were welcomed most enthusiastically and escorted to the hospital in a tonga. Nothing seems strange to me. Having heard so much and having seen the movie and so many pictures, I was already familiar with the sights here. I am working in the hospital and feel very much at home."

Those Alluring Mountains

As a last resort to defeat a stubborn case of malaria, two of the Sisters from the Holy Family Hospital were sent, in the early autumn, to the cool and invigorating climate of Murree. High up in

the first range of the Himalayas, malaria, despite its persistency, had to acknowledge itself vanquished, and the two patients soon enjoyed their enforced vacation, as their accounts testify.

"Last week we had a grand time, as we were invited to the diamond jubilee festivities of the Jesus and Mary nuns. Many of their old pupils returned for the occasion.

"The Superior arranged it so that we would not miss a thing. She is a dear old soul, over 80, and has been in India 65 years. No hopes of our getting to heaven soon just because we came to India and contracted a good case of malaria.

"There was plenteous feasting for soul and body. On Tuesday the Sisters had a Pontifical High Mass in the convent chapel. Right Reverend Monsignor O'Donohoe gave the sermon. In the afternoon there was Solemn Benediction. On Thursday, Mother invited us to a picnic in which the Sisters, lay teachers, pupils, big and little, participated. We took a long walk, having for our destination a large estate which was supposed to be unoccupied. But much to our chagrin we found it very much occupied by an Indian family who, in the kindness of their hearts, gave us free use of the lawn. Upon arrival, all were ready for the picnic dinner. The picture presented reminded me of "the feeding of the five thousand." I asked one of the Sisters if she were not afraid of losing some of the tiny tots, as they were running all over the place! 'Not in the least,' said she, 'at feeding time they will all turn up,' and they did,—not one of them was missing.

"We thoroughly enjoyed our various expeditions along the mountain trails. The mountains are most alluring and we cannot resist the temptation to climb them, despite the fact that we are fully aware of returning with blistered heels and toes."

It is a pity that the Sisters, before they attempted to scale even the more modest peaks, did not have the following notes generously supplied by a Medical Missionary who had learned by bitter experience:

"1. Virgil made one mistake; it was when he wrote that bit beginning *'Facilis descensus averno'* and going on to say how much easier it is to get down than to get up. But he is all wrong. I don't know how this idea of it being easier to get down than to get up got around, but people believe it. Perhaps it is because, while many people climbing up mountains have become discouraged and quit, it is nowhere recorded that anyone coming down ever got so discouraged that he stayed where he was or went back up. Being once up, you are

in the position of the man who hugged the bear and found he couldn't let go—you must go through with it.

"2. Snakes should be abolished or regulated. Suppose I am in a bare and steep place and see a good bush to take hold of to get me to the next step of the journey. And suppose when I have this all planned out, a snake crawls out and goes under the bush. What to do? But you will say, is there not bush enough for both? No, let us be fair. The snake saw the bush first; it is his bush; let him have it. I will not force myself upon him.

"3. Do not clutch thistles; it is a proceeding that has little to recommend it.

"4. Loose stones interfere with one's morale. You put your foot on one that looks solid and away it goes, leaping and bounding far down the crevasse. You say to yourself, like the saint who saw the man led to execution: 'There, but for the grace of God, go I.'"

SIX MONTHS ON A FRONTIER OF CHRISTIANITY

BY A MEDICAL MISSIONARY

Americans in general do not know a great deal about India. I know this from my own experience and from the naïve letters which come from home. Is it true that widows and outcastes are mistreated and abused? Is it true that suttee is still committed? It is true that occasional shiploads of our tourists come here and astonish the placid native and the conservative Britisher by seeing Delhi and the Taj Mahal and Kashmir and what not, in a series of short dashes. On the whole India is rather remote from contact with us. We get to know the Japanese and Chinese in business and in the universities, but an Indian, of the eastern variety, is certainly a rare sight among us.

So, some first impressions not of the climate or customs or scenery, but of the atmosphere of this part of India from a missionary standpoint, might interest someone. Let it suffice to say that we are here at the top end of British India, between Kashmir, which has in its whole extent three priests for three and a half million people, and Afghanistan, which has a one and only Catholic establishment—namely, a chaplaincy at one of the embassies. Our district is one where Mohammedanism has rather the upper hand over the more ancient and indigenous Hindu religion.

Just at the beginning, please note that if anybody has an idea that the missionary can come to a place like this and sit under a palm tree and instruct the willing natives who crowd around, that idea needs revision. These are a "civilized," sophisticated people; they have been in contact with Europeans for generations and all sorts of complexities are in the mission problem.

Will an Indian talk religion? He will, by the hour; he loves to do it. He agrees that the Christian system of religion is beautiful and holy—perhaps almost as good as his own. Christ was a great man and a great teacher, but only one of many who have appeared in the world during the ages. He did startling things, but see what wonders are recorded of the great men of Hinduism, or of the Prophet Mohammed. Christ was God Incarnate; a Hindu will not object to this—the Deity has at different times been incarnate in the world. Where shall we take hold of a man in this state of mind?

And what does the Indian of the north think of the missionary? Is he overcome at the thought of the noble sahib or memsahib who has left those fairylands—the countries of the West from which such wonders come, to live in his country and teach him religion? Not a bit of it. Just why they come is not entirely clear to him, but this is evidently their business in life—the way they make their living. Upon first acquaintance, they group all missionaries in with the men who look after the forests or collect the taxes, or those tiresome people who keep insisting that everybody get vaccinated. However, after we have for some time cared for their aches and pains and snatched their mothers and babies from death, they seem to view us in a different light.

Once Christian missionaries are here, they might as well be used. One can learn the ever-desirable English language very well and cheaply in a mission school; one can be taken care of cheaply and well in a mission hospital or dispensary. To conform to the peculiar notions of the sahib people, one may have to listen to talk about their religion, but it will do no harm. That some seek only the material good that the missionary can give is true. I know of one man who asked to be instructed in the Catholic religion and came faithfully for nine months for catechism lessons. Toward the close of that time he asked to be helped to a certain position and argued that, as he had come and listened to instructions so long, he should be so rewarded. When it became definitely plain to him that he would not get the position, his interest in Christian Doctrine ceased.

On Holy Thursday a man approached one of the Fathers here and urgently desired a knowledge of our Holy Books. After three-quarters of an hour of conversation a beautiful plan which he had in mind came out. He wanted to marry a certain woman who was, unfortunately, already the wife of another man. But he had heard that if one became a Christian, such a small obstacle could be smoothed away with little trouble. Would the Father give the lady a place in the mission compound, teach her the Christian religion as long as might be necessary and make her a Christian? Then the marriage would take place and everybody would be happy to have gotten so neatly out of a perplexing situation. However, the Fathers learn, long before their beards become grey and their heads bald, to weed out these insincere sons of Hindustan after their first visit.

The better class Hindu or Mohammedan tends to be disdainful of efforts to teach or improve the "depressed classes." Here in Rawalpindi they will tell you that only sweepers, a despised set of people condemned to the most menial tasks, become Christians. "Why shouldn't they? They have everything to gain and nothing to lose. If we become Christians, we should have to associate with sweepers, the lowest of men."

Does this sound, alas, alas, my brethren? It is not so meant. There is nothing to be discouraged about. Our job is different from that of workers among the simple aboriginal peoples in Garoland, or Santal land, or Ranchi, who flock to the missionaries by the thousands. We must set ourselves to a long, slow process of infiltration with schools and hospitals and house to house visiting, or whatever methods may be found useful. Humanly speaking it looks like the work of decades and generations to bring these people into the Church, but sooner or later the outpouring of the grace of God will come and the Church will have added to her fold a splendid lot of people in these Hindus and Mohammedans of the north of India.

Meanwhile, we must work as enthusiastically as if everything depended upon us. We do the one thing required of a missionary—we plant the Church, with its channels of grace. We cannot force non-Christians to drink of its saving waters. But with good example, courage and charity, the time will come when they will. If anyone has an idea, however, that merely efficient methods will effect the work of conversion, a short contact with the Mohammedans is guaranteed to remove that idea perfectly. It waits upon God's time and that, perhaps, waits upon prayer.

HIGH SPOTS ON A MISSION CRUISE

ANNA DENGEL, S.C.M.M., M.D.

ON TO SOUTH AMERICA

During our next six days at sea, time did not hang heavily on our hands. The cruise director, well seasoned in crowd psychology, never left us long without action of some sort. The first major event was the crossing of the equator. We could not miss it, for, on the eve, Neptune and his better-half, Thesis, followed by a retinue of musicians, high and mighty personages and negro guards, paraded in pre-Noah style costumes around the deck. Finally the importance of the leap from the northern to the southern hemisphere was set forth in solemn speeches. The most refreshing part, at least for the participants, was the baptism required of those landlubbers who wished to become subjects of the king of the seas and who were so green as never to have crossed the equator before. Four blackened sailors dipped the neophytes, one by one, up and down in a huge tank, after the barbers had given their faces a good lathering. Any particularly popular passenger received an extra dip with each extra clap. The costume prescribed, of course, was a bathing suit.

We were actually at latitude 0.00 and longitude 42.50 west on January 19 at 1.45 p. m. The foghorn sounded furiously when we crossed the line. At night, we looked out for the Southern Cross and saw it clearly among a myriad of other twinkling constellations.

On January 20, news of the death of King George the Fifth was flashed across the Seven Seas. The following day an Englishman on board gave an address of condolence and of appreciation of the late King as a father of his subjects.

As we were nearing our first port of Brazil, it was timely to hear something of the country we were about to visit. The two learned gentlemen, who were on the cruise staff in the capacity of lecturers (one American and one German) now began their series of travelogues which contributed so much to a better understanding of the places we saw. As the German lecturer holds a professorship in Chile, he was naturally very much at home on the South American continent. It harbors 85,000,000 people, of whom almost half are in Brazil, he told us. One quarter of the population is white, of whom

Germans and Italians are in the majority; one-quarter, negroes, and half are of mixed blood, mulattoes (white negro), mestizzoes (white and Indian), and zambos (negro and Indian). The Oriental races are also represented.

South America has many natural resources, both mineral and vegetable, but the lack of coal is an obstacle to the development of industry. Another drawback is the labor question. The people have not the same energy and spirit of enterprise as northern races, our lecturer told us, and their capacity for work is further diminished through diseases and a low standard of living. The big industries are almost exclusively in the hands of foreigners.

One of the first things we think of in connection with Brazil is good coffee. We learned what a long and toilsome road it has to travel before it reaches our cups on the breakfast table. The virgin forest has to be cleared by the sweat of the brow, the soil tested, and protecting trees provided in some regions. The coffee tree itself demands meticulous care and it does not tolerate any rivals in the shape of weeds. Only after four years does it begin to bear. The plantation of coffee and also its export is controlled by the state in order to keep prices at a desired level. India, Arabia and the Dutch East Indies also grow coffee, but Brazil furnishes by far the greater part.

Strange to say, coffee is not the national drink of the natives; it is too expensive. They drink maté, the leaf of the tea tree, which grows in southern Brazil. The leaves and even stems are cut, dried, redried and then pulverized.

Our lecturer maintained that the reason why many natives are so poor is the fact that slavery was stopped very suddenly in 1888. Before that time, slaves were fed and housed well; it was to the interest of the owners to look after their health. When they became free and were left to their own devices they became, in many cases, helpless and neglected. He also told us that the colored people are very good natured, but not as well educated as the negroes in the United States.

AT THE MOUTH OF THE KING OF RIVERS

Not very far below the equator we passed the delta of the Amazon, the mightiest river of the world. It is navigable for a distance as far as from New York to Chicago. In its course of 2,400 miles, no less than 100 rivers join its course. The rainfall in the valley is very high, as much as six feet a year in some regions. In the interior there

are still enormous virgin forests and swamps. Many beautiful birds, insects and wild animals can still enjoy the silence and solitude of these untouched regions. I only wish we might have had at least a bird's eye view from an aeroplane, but alas! we couldn't. The variety of the flowers is said to be such that a lifetime would not suffice in which to make a complete study of them. No doubt, many of Brazil's 200 different types of poisonous snakes move about in these dense jungles. The government advises the wearing of leather boots in dangerous places and distributes a serum free of charge, which is made on the snake farm in the experimental institute of Sao Paolo. We saw pictures of neat little dome-shaped houses and the manner in which the dangerous guests are fed sumptuously to make them sluggish. This sluggishness facilitates the removal of the venom, which is done about every two weeks. The keeper seizes the snake behind the head with wooden pincers; an assistant holds a small glass dish (a Petri dish) under the head while the attendant squeezes the glands in the back of the head. Two clear, thick drops of the poison fall into the dish. The poison is injected into horses and donkeys. This serum, in turn, has a curative effect.

THE CITY OF 200 CHURCHES

Our first stop in South America was Bahia. From afar the many imposing church steeples on the brow of the hill told us that silent tale of an old Christian civilization. On coming nearer and especially on actually going through the streets and lanes, we saw that much of the glory was a thing of the past, but of a great past. Bahia, the oldest city in Brazil, was founded in 1542 and remained the capital for 250 years. Its 320,000 people live partly in palatial, partly in old-time style and partly in rather tumble-down looking houses. We passed the well-stocked shopping center on our way to the famous gilded church, which is government property but in the custody of the Franciscans. I have seen many beautiful churches, but never one which was so ornate. The whole interior is covered with heavily gilded wood carving. Our guide, a Franciscan friar, had all the lights put on for us. The effect was dazzling, to say the least. Although we sober northerners prefer severe beauty we cannot help but marvel at and admire a people which expressed its love of God in such splendor and art. As a little digression, may it be mentioned here that a Franciscan Father told us of one place in Brazil where, in bygone

days, women loaded their hair with gold dust on certain occasions and shook it into the holy water font, in the church. They say that there is nothing new under the sun. I would like to know where such church collections took place before or since!

To come back to our church. In it we were shown two remarkable statues, one of Saint Peter Alcantara, a masterpiece of the personification of asceticism, carved by a Brazilian, and another of good Saint Anthony, who up to a few years ago had to put up with the full regalia of a Portuguese general, sword and all, in thanksgiving for a victory attributed to him. I am sure he is much happier now since his brown robe has been restored to him.

The altars were ancient and precious and, strange to say, decorated with artificial flowers. On inquiring we learned that fresh flowers are at a premium because of a species of ant, with a refined taste for flowers, that can denude a whole garden in one night.

The presence of a statue of Our Lady led to the remark that the Brazilians do her great honor every year, on the last day of May, when they crown her amid great processions and festivities.

Nominally, 99 per cent of the population is Catholic. Different denominations are working hard amongst them.

Negroes were so predominant that one almost felt transported to Africa. That may, perhaps, be explained by the fact that for a century Bahia was the largest slave market of South America. With a stretch of the imagination one can conjure before one's mind the scenes of bartering for human beasts of burden. How sad that such things existed and still exist!

Strolling around the lower city before returning to the boat, we came upon a majestic looking church with two steeples and a broad flight of steps leading to the portals, which, however, were closed. We noticed quickly that it was deserted. Adjoining was a large rectangular structure which had little niches built into the walls. We had heard from our Franciscan guide that it was customary to preserve the bones of the dead in little coffins which were placed in such niches. Outside the cemetery was a sarcophagus containing the remains of Sister Theresia de Jesus. From this we gathered that a monastery of nuns had been attached to the church and had vanished like many other glorious things.

RIO DE JANEIRO

We sailed into the harbor of Rio de Janeiro on the afternoon of January 24. The extensive bay with its graceful curves, the rocky

islands dotted here and there, the peaks and hills on the distant horizon, the Sugar Loaf mountain standing sentinel at the entrance and, most impressive of all, the Statue of Christ, in gigantic dimensions, on the hunchback mountain with the blue sky domed over all makes the use of a superlative pardonable. Many call it the most beautiful harbor of the world. I agree with them, after having seen several others for which the same distinction is claimed.

The city itself did not fascinate me so much, in spite of its fine buildings, broad avenues, parks and so on. Although supposed to be modelled on Paris one can see that it is the product of peoples of many nations. One marvellous thing about it is its excellent sanitation. It ranks among the healthiest cities in the world, which is a remarkable achievement considering the mixed population and the climate. It is clean; it has a good water supply; no malaria, no devastating epidemics. I heard, but I had no opportunity to verify the statement, that the city employs 5,000 health inspectors (It has 1,500,000 inhabitants) who examine each house regularly every week for unsanitary conditions, contagious diseases and the like.

There are a number of very fine hospitals. We visited the German one. It has a capacity of 100 beds and is conducted by deaconesses. It is a miniature sky-scraper, built high in order to minimize the effect of the local miasmata and also to facilitate the running of the hospital. It is built cross-ways to the prevailing winds, which helps to make it much cooler, as we ourselves noticed. Whilst it was sweltering hot in the city, it was pleasantly cool at the hospital.

Naturally my inquiries regarding provision of health did not stop with Rio. A few explanations or statistics, however, are not of much value. One would have to live in the country for a considerable time in order to obtain a true picture. A 1930 League of Nations publication regarding infant mortality in South America, which chanced to come into my hands, interested me because it was written by local experts. According to their verdict, maternity and child-welfare have still a long way to travel in South America although some of the excellent welfare and maternity institutions contain, in embryo, all the factors essential for a well-organized campaign against infant mortality. The number of infant deaths is not accurately known in certain districts because the practice of secret burials still exists in spite of efforts to prevent it.

Obstetrical care, by a doctor or midwife, is insufficient in the

towns and almost totally lacking in rural districts where, if it is available at all, it is given by unqualified midwives. In Brazil, the situation is serious and steps have been taken, with good results, for the instruction and supervision of these midwives. All the experts laid stress on one of the most influential factors in infant mortality, namely, ignorance and a comparatively low level of general education. To this lack of knowledge may be attributed serious dietetic errors, lack of medical supervision of sick children, obstetrical care by unqualified midwives, the persistence of prejudices and superstitions and faith in curanderos (quack). The problem of education is rendered more difficult by the diversity of races living side by side.

The leprosy problem also occupies the Brazilian government at present. With the assistance of the League of Nations it has just founded a large, well-equipped leprosy center in Rio de Janeiro. The lepers of Brazil are estimated at 50,000. The new center in Rio will cooperate with other South American countries, many of whom also have a goodly number of these poor people.

Another interesting point regarding health was brought to our notice by the Benedictine Sisters of Tutzing whom we visited in their Collegio San Amaro. They, jokingly, said to us: "You should go to our mission on the Rio Branco (a province in Northern Brazil) where there are no doctors far and wide."

While we were in search, of course, of things missionary and medical, we did not neglect our general education. We tried to see whatever was to be seen; it all belongs to life and leads to a better understanding of it.

Our first full day in Rio de Janeiro was a Sunday. We went to Mass at San Bentos, a beautiful old Benedictine Church.

The day brought many worthwhile sights. One of the first was the famous palace of the king, which is now the national museum. I spent most of the short time at my disposal looking at the splendid display of costumes, masks, weapons, tools, ornaments, etc., of Indian tribes. The feather jackets and headgear show a marvellous taste for combination of colors. They are a pleasure to look at. They are gems of art. I understand at last, why Indians were so fond of wearing feathers. The art might well have flourished there; they had so many colored birds at their disposal.

A variety of heads of Indian tribes were shown, as well as the compressed skulls of victims. In a side room were skulls of many races, a most interesting collection. Just glancing over them quickly,

the broad cranium of a specimen from a Mexican tribe struck me as being very extraordinary. The public garden in which the museum is situated is one of the finest. There we saw the Victoria Regia for the first time.

We had lunch at the Gloria Hotel, situated on the strand. People go bathing at all hours. They walk or drive to the beach in their bathing suits. After a swim, they take refuge under a huge, colorful sunshade and take the world easy as only southerners can.

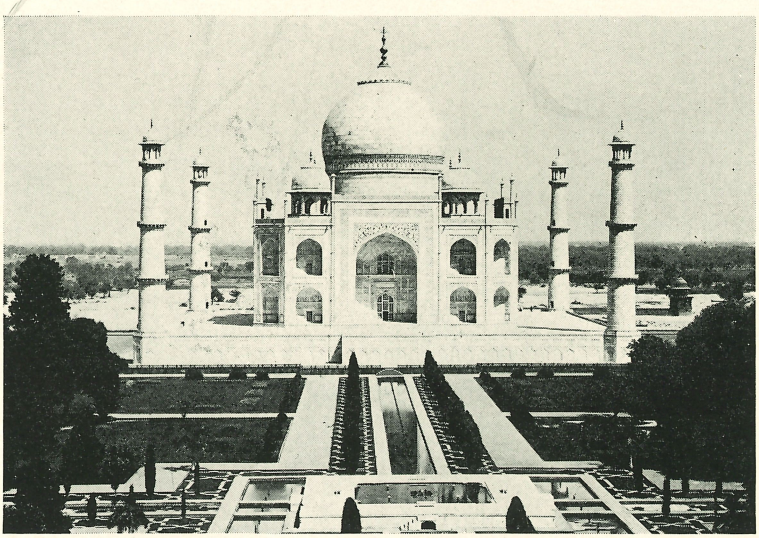
In the afternoon, cars puffed us up 2,400 feet to the Corocovado (hunchback mountain), the pedestal of the Statue of Christ. The statue is huge. The index finger alone measures six feet. It is hewn out of Brazilian stone. The artist succeeded in giving it a noble expression and pleasing proportions. The spot for the King of kings could not have been better chosen. It dominates land and sea and is a beautiful expression of the faith, hope and love of a Catholic people.

In the evening, we witnessed an extraordinary spectacle. It was the opening of the carnival season. The Avenida Branco became alive with a stream of human beings of the most varied types I have ever seen or ever expect to see again; bronzed Europeans, who could scarcely be distinguished from the native Brazilians, Negroes, Mongolians, and an endless variety of figures, heads, eyes, noses, hair, coloring, expressions of mixed races! To have seen so many types of physiognomies I count as one of the outstanding sights of my journey around the world.

The amusements provided were very simple. Little groups of Negro boys passed, playing on primitive instruments or beating boxes as drums; the crowd watched them with delight. On elevated stands boy and girl musicians held sway. Some were dancing in the streets; the upper ten, in hotels. The illumination was marvellous. The electric works of the city, we were told, are in the hands of a Canadian company.

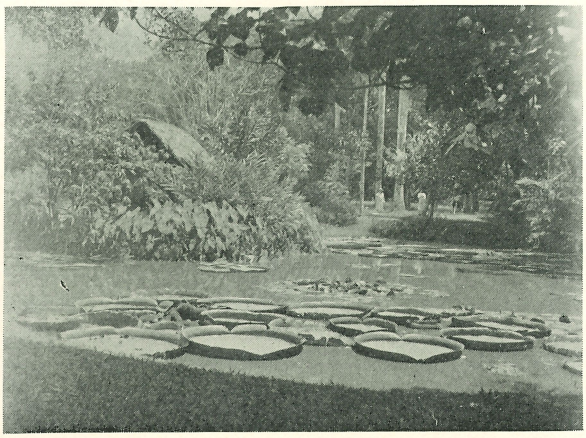
I suppose every visitor to Rio de Janeiro is advised to take an excursion to the Tejuco mountain; it pays, indeed. The verdant hillsides, the tropical trees, the vistas over the bay, and the 16 miles of city along it, are a feast for the eyes. On the way up, we saw a cave which was inhabited by Indians up to 130 years ago. It was a most picturesque, spacious habitation. The windows were natural slits between rocks. The roof of one of the apartments was a huge slab of stone, 20 feet thick. A streak of lightning had split it through and through. I was glad to have seen a cave which had been inhabited

Mumtaz Mahal, Mother of Fourteen Children, Lies Buried in the Taj Mahal, in Agra



"That Exquisite Rhapsody of Architecture, the Taj Mahal, Stands as a Silent Monument to the Memory of a Brave Mogul Queen and Mother"

(See page 5)



A Glimpse of the Victoria Regia and the Exuberance of Tropical Vegetation in Rio's Park

"We Saw the Harbor in a New Mood. Peace Seemed to Hover Over It. The Illuminated Figure of Christ Appeared Floating in the Air As Its Mountain Pedestal Was Enveloped in Darkness"

once upon a time. Living in it, probably, had not been so bad at all. Very likely there was plenty of fresh air and no crowding. Undoubtedly, the inhabitants had ways and means of protecting themselves from the inclemencies of the weather.

One of the last treats we had in Rio de Janeiro was our visit to the Franciscan Convent of San Antonio. We boldly asked for a priest who could tell us something of the missions, and had the good fortune of meeting Father Piedro Zuntzig, O.F.M., who is a distinguished writer. At the time of our visit he was very much interested in the position of the Catholic Church in Germany as he was writing a series of articles on that question. I asked him whether or not Brazil was a missionary country. "Yes and no," he said, "There is a lot of illiteracy and conditions in the interior leave much to be desired."

Whilst our few days stay in Rio gave us only a glimpse which made us wish to see more, yet we left richer in many ways—money excepted. The currency of milreis (17 to one dollar) made exchange complicated. The tricks of a few rascals made us soon realize that it was necessary to make calculations with paper and pencil in hand.

As we sailed out of Rio de Janeiro in the evening we saw the harbor again in a new mood. Peace seemed to hover over it, the illuminated figure of Christ appeared floating in the air as its mountain pedestal was enveloped in darkness.

To Be Continued.

LADY DUFFERIN

At her home in Chelsea, England, on October 25, Lady Dufferin died at the age of 93. Throughout her husband's brilliant career she was constantly by his side and was his invaluable helpmate. Although she had seven children, the peoples of her husband's domain received a share of her interest and attention.

During Lord Dufferin's viceroyalty in India, Lady Dufferin founded the National Association for Supplying Medical Aid by Women to the Women of India. Its object was and is to open women's hospitals and women's wards in existing hospitals; to train women doctors, nurses and midwives in India and when necessary to bring them out from Europe. It has not only functioned since 1885, but has been enlarged and has contributed much towards the alleviation of suffering of India's many poor women and children. Stimulated by her example, every vice-reine since has inaugurated or supported a movement for medical relief for the women of India.

HISTORY OF MEDICAL MISSIONS

MICHAEL A. MATHIS, C.S.C.

This is the second article in a series on Dr. Thomas Ohm's book, "The Medical Contribution of Catholic Missions." The reason for the series is a desire to share with our readers a knowledge of the valuable investigation in medical missions shown in this scholarly work about the medical mission apostolate.

The first article, which appeared in the July issue of THE MEDICAL MISSIONARY, reviewed in detail Chapter 1. It dealt with Our Lord as the Founder of Catholic Medical Missions. I am sorry now that I ended it on a note of criticism, because I might have failed thereby to emphasize the positive value of the chapter as much as it deserves. The present article takes up the second chapter, "The History of Medical Missions." The subject is one of singular importance for all those engaged in or concerned with the care of the sick in the missions, for it is an effort to link up our present-day activities with those of the past.

Dr. Ohm's chapter on the history of medical missions is one of the most comprehensive reviews of this subject published to date. Yet it would be impossible for the author to present a complete and exhaustive study of such a large and unexplored field within the limits of one chapter. In order to understand the status of medical missions at various times it is necessary to know something of the historical background of mission and medical history. To clarify this section I venture to sketch this background very briefly into the substance of this review.

The chapter is divided into the four usual periods of mission history, The First Centuries, The Middle Ages, The Era of the Great Discoveries, and Recent Times. A short summary may serve as a well-earned tribute of praise for the patient digging and the valuable researches that have gone into the make-up of this chapter.

THE FIRST CENTURIES

After a short explanation of the change in the Graeco-Roman world's attitude toward the sick, brought about by the Christian concept of the true worth of the body as well as of the natural and providential character of bodily illness, the author devotes a few

pages to the discussion of the miraculous cures wrought by the apostles and their importance for the propagation of the Faith.

Although the command and the example of Jesus in His cure of the sick dominated the period, still it had its own way of translating these ideals into action. One feature is noted by Saint James: "Is any man sick among you? Let him bring in the priests of the Church and let them pray over him, anointing him with oil in the name of the Lord" (V:14). The same idea of calling the most responsible and eldest of the Christian community to the sick is repeated in many other documents. Hippolytus, for example, says: "It is the bishop's task to arrange for the care of the sick." This was more characteristic of the Christian community while the charismatical gifts of healing were common and it continued, to a certain extent, even after they became rare and when the care of the sick was institutionalized into a work for deacons and deaconesses. Among these are to be noted especially Saints Nicerata and Fabiola, who erected the first hospital in Italy (380); the martyr, Theodosia, a physician and surgeon (312); and the better-known Olympias, who practised at Byzantium about 400. Even bishops like Theodotus of Laodicea and Basil of Ancyra practised surgery.

The Xenodochia also are distinctive features of this period. They were institutions for the relief of distress of all kinds, including sickness. One of the oldest and best known is that built in Caesarea by Saint Basil between 370 and 379. In these, monastic doctors and nurses cared for the sick. A good example of the missionary value of these Xenodochia is the good impression they made even on the apostate Emperor Julian, who marveled at the care lavished on the sick, pagans and Christians alike.

Another characteristic of this period was the prominent place given to prayer in behalf of the sick, the realization of the importance of sympathetic visitation as demanded by Christian charity, and the frequent use of the Sacraments, especially Holy Communion and Extreme Unction. These qualities gave even the technical care of the sick a distinctly Christian character.

THE MIDDLE AGES

With the breaking up of the Roman Empire and the transmigration of the nations, the Graeco-Roman civilization, including medical science, suffered a severe setback, and the vocational missionary, the monk and, to a certain extent, the nun, came into prominence in the conversion of the Celts, the Teutons and the Slavs. The

medical apostolate was practised particularly by the monk and the nun. Indeed, it was they especially who retained for Europe something of the Greek medicine of Hippocrates and Galen. Each convent and monastery had its infirmary. Especially famous was the Abbey of Saint Gaul, in Switzerland, where, as early as the eighth century, there was a leper asylum, water cures and a hospital. In the gardens of the abbey medicinal herbs were grown. The study and practise of medicine by nuns was also of a high order. Thus Saint Clotilde and Saint Radegunde, the Abbess Herrade of Lansberg and others had convent hospitals in which nuns practised medicine with great skill. Among these, Saint Hildegarde, because of her medical eminence, enjoyed an unusual prominence.

The medical works of monks and nuns, says the author, gradually declined between the years 1131 and 1247 because of ecclesiastical legislation which forbade monks and nuns to study medicine or to engage in what was then surgery, cutting and burning of the human body. An historical study of this legislation and its practical effect on the subsequent medical apostolate in foreign missions would be very enlightening. Yet the author is not correct in leaving the impression that this was an absolute prohibition, because it was not. Permission could be obtained for such studies and practise, and this holds good even today when the Sacred Congregation of Propaganda (February 11, 1936) urges sisters to study medicine and midwifery for the care of women and children in mission lands.

The Crusaders brought other medical agencies into being in the Middle Ages, such as the Teutonic Orders. These conducted hospices in Jerusalem, Acre, Antioch and other cities of Palestine and the Orient. Of these Schiller sang: "Religion des Kreuzes, nur du verknüpfest in einem Kranze der Demut und Kraft doppelte Palme zugleich."

Finally, it is interesting to note the plan of Pierre DuBois, inspired by the needs of Mohammedan lands, to found an institute where women might be prepared medically and from the missionary standpoint for work in the Orient, the purpose being to win unbelievers to the true Faith through their medical knowledge, devotion and virtue. This plan was presented to Edward I of England but nothing ever came of it.

PERIOD OF THE GREAT DISCOVERIES

The discovery of America (1492) and of the new route to India (1498) opened up the world's highways for what Professor Schmid-

lin, the father of Catholic mission science, calls the "full-bloom period" of Catholic mission history. It was but natural that in this period, distinguished for our most eminent theoretical mission writers at home and for practical conquests far afield, the care of the sick should have played a part. However, it could not have been so distinguished a part as later for the simple reason that there was not then the notable difference between medicine in Europe and that in foreign mission lands as exists today.

The Reformation at home greatly aided medical missions in a strange way. The reformers, by insisting on salvation by faith alone without works, created a special opportunity for Catholics to emphasize the correct doctrine, namely, the necessity for a living faith proving itself in works of charity.

This period has, moreover, a special importance because it witnessed the publication of the first medical mission manuals. Among these should be mentioned Gregorio Lopez's book written in Mexico in 1580. A more important one of the same period was a "Summa" on surgery written by a Spanish doctor and Jesuit lay-brother, Alonso Lopez, who was a medical missionary in Mexico for 14 years. A similar work, also from Mexico, was published in 1579 by the Augustinian doctor, Augustine Farfan. In 1615 we have another Mexican book, "De la Naturaleza," by Francesco Hernandez, and "Libro de Medicinas" from the Philippines, by an Augustinian, Ignatius Mercado, who died in 1698. Besides these, there are the medical works of the Jesuits, Clain, Esteyneffer, Montenegro, John Schreck and Trigault; of the Augustinian, Cacho; and of the Franciscan, Gimbert. Finally, the first book printed in India was one on medicine, and it was published at Goa.

Priest-doctors who distinguished themselves in medical missions numbered more than might be supposed. Here we can mention only the most noteworthy. Father Franz Storrer, S.J., opened up Abyssinia to Catholic missions by his medical ability. Father George Chikelio, S.J., practised medicine in Syria, and Father P. Kaller, S.J., was so renowned a doctor in Morocco that he was much sought after. The Paris foreign missionaries, in the seventeenth century, began their Chinese missions with doctors. Father John Siebert, S.J., was the personal physician for the court mandarins of Cochin China, while Father Karl Slemensky and Father John Koffler were personal physicians to the kings of the same country. In some missions there were also hospitals. One of the most famous was that conducted by the Brothers of Mercy at Mozambique. Yet, on the whole, there was

no proportion between the need and the supply of medical facilities. Hence, in this period, charismatical healing, such as the cures ascribed to Saint Francis Xavier, came more prominently into view.

MEDICAL MISSIONS IN RECENT TIMES

It is impossible to understand the rise of modern medical missions, first through Protestant missionaries and then in Catholic missions, in the nineteenth century without a picture of the missions, on the one hand, and of medicine and nursing on the other.

At the beginning of the nineteenth century, the great Catholic mission movement, inaugurated during the period of discoveries, had not only come to a standstill but its conquests were languishing and threatened with extinction by the cutting off of missionaries from Europe. The political decline of Portugal in the East where missions were largely dependent on her for men and supplies; the expulsion of 2,171 Spanish, 909 Portuguese and 196 French Jesuits from the missions between 1759 and 1767; the final suppression of the Society of Jesus in 1773; the French Revolution and its sequel that prevented the two largest foreign mission seminaries of the time, Paris and Propaganda in Rome, from sending priests to the missions from 1775 until 1820, all combined to lay prostrate Catholic mission activities.

The resurrection of Catholic missions came only gradually, beginning in 1834 with the elevation of Gregory XVI as Pope. Naturally, it became a question of fundamental organization in which the channels of grace had to be provided through bishops and priests.

The first sisters to enter the foreign mission field, as regular missionaries, were the Sisters of Saint Joseph of Cluny, in 1817. I note this fact for the reason that sisters are the logical people in the Catholic Church to establish and conduct hospitals, and these could not have opened hospitals in the missions before the nineteenth century.

It is also important to point out that the great development of both medicine and nursing began about the year 1850, at a time when Catholic missions were being revived and when Protestant missions had a good start. Without underestimating the great achievement of Protestants in the field of medical missions, the delay of Catholic action in this sphere until the second decade of the twentieth century can, with this historical background, be very readily understood.

The history of Protestant missions is most interesting. Dr. Schmidlin writes: "That both in its origin and in its essence the

Reformation was indifferent or hostile to pagan missions from the very first is now generally conceded and is openly recognized even by Protestants." This attitude was based on their doctrine that faith without works was sufficient for salvation, and other doctrinal grounds. The Protestant missionary movement began and developed during the seventeenth and eighteenth centuries with the colonial conquests of dominantly Protestant countries, first Holland, then England and finally Denmark and Germany. By 1850 they were in a better position than Catholics to take advantage of the phenomenal development of medicine and nursing, at the time, not only from the standpoint of the increased medical knowledge made available but also from that of personnel. The fact that Protestants used lay missionaries for this activity (both men and women), who could more easily take up medical studies and work than priests and sisters, gave them a decided advantage over Catholic missionaries.

England and America share the honor of having been the first to promote Protestant medical missions. An American, Dr. Clara Swain, was the first woman medical missionary. She sailed for India in 1860. The Edinburgh and the London Medical Missionary Society, and, in America, the International Medical Missionary and Benevolent Association, were well-established organizations in full swing before the close of the last century. In 1906 the Tübingen Institute for medical missions, in Germany, was added, and many others followed.

At the earliest possible moment, Protestants, with studied foresight, started the training of native nurses and doctors, with the result that at present the native personnel of their mission hospitals, in countries like Japan, far outnumbers the foreign doctors and nurses.

An idea of the phenomenal development of Protestant medical missions may be gathered from the following statistics: In 1908 there were 894 Protestant doctors on the field. In this number are included 305 women doctors. They hailed from the following countries: 433 from America, 425 from England, 10 from Scandinavia, 5 from Holland, 3 from France and 18 from Germany. By 1910 they had 982 doctors, 4,400 nurses, 550 mission hospitals, and 1,024 dispensaries, 111 medical schools, 93 schools of nursing for natives, 103 sanitoria for opium addicts and 88 leper asylums.

The high-water mark of Protestant medical missions came in the early years of this decade, as shown by the following statistics: Japan (1932), 11 foreign and 80 native mission men doctors, 2 foreign

and 6 native women doctors, 15 nurses and 13 hospitals; Korea (1931), 107 mission doctors, 332 nurses; China (1932), 788 mission doctors, 1,047 nurses, 214 hospitals; India (1932-1933), 89 foreign and 718 native men doctors and nurses, 191 foreign and 1,168 native women doctors and nurses, 299 hospitals, 376 dispensaries, 65 leper asylums, 11 tuberculosis sanitoria, 12 homes for the blind, deaf, etc.; Dutch East Indies (1932), 56 foreign and 4 native mission doctors, 80 foreign and 673 native nurses, and 23 hospitals; South Africa (1928), 30 men doctors, 4 women doctors and 101 foreign and 54 native nurses.

I have stated that the high-water mark of Protestant medical missions was reached about 1931. Since then there has been a decline, but whether this is due to the depression the future alone can tell.

Much later came the development of professional Catholic medical missions. To be sure, the number of places and persons who were concerned with the care of the sick in Catholic missions has always been notable, but professional medical care, according to western standards, performed by missionaries giving their whole time to it in the same exclusive way in which Protestants do, was too often woefully lacking. The first institute to be founded for that purpose in the Catholic Church was the Würzburg Medical Mission Institute, Würzburg, Germany, in 1922. This was followed in 1925 by the Society of Catholic Medical Missionaries, Washington, D. C., the first community of religious women founded exclusively for the professional medical care of women and children in foreign mission lands. About the same time other organizations in France, Belgium, Holland and our own country came into existence. The author has very graciously expanded on the foundation and work of our own Society and enumerates with great care and describes, often from personal acquaintance, the present status of the various medical mission activities at home as well as on the field. As this book was written just before the latest statistics of Propaganda were published, in 1934, the figures are slightly out-of-date, but the impression of the whole is still sufficiently accurate to retain its value: 226 doctors, 692 hospitals, 1,857 dispensaries and 81 asylums. It is difficult to determine the size of the hospitals and the number of nurses, both brothers and sisters, but it is quite certain that a goodly number of the 50,000 foreign and native Sisters are engaged in this apostolate.

Dr. Ohm's book was written, also, before the epoch-making Instruction of the Sacred Congregation of Propaganda, February 11,

(*Continued on page* 44)

A MISSION EXHIBIT IN RETROSPECT

By Dr. Anna Dengel

Mission Exhibits are considered useful even in small countries where it is comparatively easy to make things known. In a large country like America where distances are so great and where propaganda is so prolific that news of one event is quickly drowned out by that of another, personal contact and ocular demonstration seem necessary in order to make deep impressions. To judge from outward appearances the Mission Exhibit held in Worcester, Mass., from October 14 to 18, accomplished its purpose of making visitors realize what a network of achievement and endeavor the Catholic Church has cast over the whole world.

In the presence of many monsignori, priests and religious, His Excellency, the Most Reverend Thomas M. O'Leary, D.D., Bishop of Springfield, solemnly opened the Exhibit with words of such welcome and zeal that one was genuinely happy to be a participant.

The Reverend George J. Hurley, Diocesan Director of the Society for the Propagation of the Faith, on whom fell the task of organizing the exhibit and of which he acquitted himself admirably, introduced two guest bishops, Their Excellencies, the Most Reverend Joseph Reiners, S.V.D., D.D., Prefect Apostolic of Nagoya, Japan, and the Most Reverend James E. Walsh, M.M., D.D., Superior General of Maryknoll. Bishop Reiners, who had labored 25 years in Japan, spoke of the slow but steady progress of Catholicism in the Land of the Rising Sun and said that there are now 105,000 Catholics in Japan. He mentioned that he had often wondered why it was that missionaries were so dependent upon others. The conclusion he had come to was that it is God's will that all take part in the great work of the spread of His Kingdom on earth.

His Excellency, Bishop Walsh, stressed particularly the great and unique opportunity for missionary work today. He reminded us that it was never so great before, and emphasized our responsibility of seizing it lest it pass never to return.

The beautiful and spacious Worcester Auditorium lent itself admirably to the mission displays. Making the rounds of the 40 booths reminded me of a trip around the world on a miniature scale—one minute one saw pictures of Alaskan snows and the next Samoans in tropical attire. The exhibit of the Society for the Propagation of the Faith was the center around which the others clustered. There

Reverend Father Hurley and his untiring helpers were ever ready with information and assistance. The booth harbored a valuable treasure, a letter written by Father Damien himself to a Sister of Mercy in Worcester. This short letter gives the spirit of the great apostle of the lepers as clearly as any book could do. I copied it. It begins as follows: "Your kind letter of the fifth inst. is on hand and as you say, I am somewhat surprised though I suspected that my name should be known to many sympathizing Christian souls, through the writings of our friend, Ch. Stoddard.

"The terrible disease, which Almighty God permits to break out on me soon, was anticipated from my first arrival into this leper asylum 13 years ago, and voluntarily accepted beforehand, and I hope that, helped by the prayers of many, our Lord will grant me the necessary graces to carry my cross behind Him on our peculiar Golgotha of Kalawao. So far, my health permits me to do my regular service, as heretofore. . . ."

The nearest neighbors to our booth were the Sisters of Mercy who have missions in Jamaica. To me, the most impressive part of their exhibit was a simple sentence on the wall, words of Mother McAuley, "The Sister of Mercy speaks to God of man, and to man of God."

Opposite us was the booth of the Holy Childhood. Babies! Babies! was the keynote there. What a happy inspiration it was to establish an organization appealing to children, giving them the opportunity of participating so early in apostolic labors.

Vis a vis too, we saw pictures of Jamaica flash on and off and in the background, statistics of Jesuit Missions all over the world with Saint Francis Xavier in the center.

A real live Indian chief in gala attire was the sensation in the booth of the Sisters of Saint Ann.

Among other things in the booth of the Franciscan Missionaries of Mary, a life-size figure of a Chinaman bringing a basketful of abandoned babies to the Sisters, made a great impression.

The map of China, with the picture of the Catholic University of Peiping in the center, sending out rays of light into all parts of that vast country, must have appealed to all who realize the need of leadership in the new republic. Another inspiring map was that showing the work of the Christian Brothers in 57 countries.

The White Sisters had a Beduoin Tent among their display and the Maryknoll Sisters a native novitiate. The Marist's booth was a

regular museum of the South Sea Islands. The Holy Cross Fathers gave the visitors the benefit of a glimpse at the Taj Mahal and the Maryknoll Fathers showed a priest baptizing a native.

At the Passionist booth, Reverend Raphael Vance, C.P., invited passersby to return at a certain hour to listen to Chinese cries and actors' falsetto voices, which he renders so admirably. Father Raphael has launched a new method of street preaching in China. He also gives first aid, thus combining the spiritual and corporal works of mercy. Sulphur mixed with butter makes a good improvised ointment for certain skin diseases, he told me. Missionaries have to be resourceful! He showed harrowing pictures of famine-stricken victims in his field of labor. He told me that it was a three weeks' journey to the nearest hospital from his mission station. He became seriously ill several years ago and Sister Devota of the Sisters of Charity of Elizabeth, N. J., nursed him until she became ill herself. She died; he recovered.

The Sisters of Notre Dame de Namur exhibited among other things some copy books and needlework of their pupils in Japan, showing that their students are not behind ours. It must be a pleasure teaching them, especially since they are so imbued with politeness and docility.

A Holy Ghost Father, who has labored many years in Africa, told me of the missionaries' great difficulties with witch doctors. They know many remedies and help many times, he said, but as their work is interwoven with superstition, to say the least, Catholics are not allowed to go to them. The only way to prevent these recent Christians from consulting witch doctors is to provide other means of medical care for them. He mentioned that among primitive tribes women can reason with and help women much more easily than men and that maternity and child-welfare work is very much needed in Africa.

Needless to say, the home missions aroused great interest. The Extension Society, the Josephite Fathers, the Trinitarians, the Missionary Catechists, the North Carolina Missions, etc., all showed the great field at home.

A guide book to the forty or more booths would make a good-sized pamphlet. Here space permits me only to allude to a few at random to show what variety was offered.

Our exhibit, although simple, had many interesting and interested visitors. The Holy Family Hospital in Rawalpindi reproduced in

miniature with chapel, wards, operating and X-ray rooms, etc., evoked many inquiries as to conditions in India. The Bengali huts gave a slight idea of the maternity and child-welfare work of our Sisters. One lady, after scrutinizing everything very carefully, said: "It is so sad!" "What is sad?" "Oh, to go out so far and to look after these people." We could not help but smile as we consider it a joy to be permitted to help them. One old Lithuanian grandmother pleaded to be allowed to go out and help us look after the babies. A doctor, 87 years of age, brought us his instruments to use on the missions. It was touching. Most people like to cling to their tools even if they cannot use them anymore. To give them up is a sacrifice. It is like a separation from old friends. At the eleventh hour, the Mayor of Worcester on his rounds, made a halt at our booth, an honor we appreciated very much.

Streams of people moved along the booths from 2 o'clock until 10 for five days, and the Little Theatre, where lectures and movies were given continuously every day from 3 o'clock until 9, was always well patronized. It was a grand success.

On the closing day, the King of kings, who was enthroned in a temporary chapel during the whole exhibit, was carried by His Excellency in solemn procession through the beautiful auditorium, past the exhibits. Besides a great number of priests, brothers and sisters, little boys and girls, dressed in the habits of the various mission congregations, took part. These little missionaries were symbolic of the eternal youth of the Church; in all ages, in all generations, new apostles appear to take the places of the old.

Last, but not least, I would like to say that our stay in Worcester during the time of the exhibit was made very pleasant by the wholehearted and generous hospitality of Reverend Mother M. Aloysius and all the nuns of the Convent of Mercy and by the kindness and interest on the part of those we met. The memory of it all will remain green in our hearts.

(*Continued from page* 40)

1936, which urged not only the foundation of more communities of Sisters like our own but also the setting aside, for the same purpose, of Sisters in older communities which were not founded exclusively for the medical apostolate. Personally I am convinced that this decree of the Catholic Church will bring about a great period of expansion and development in medical missions so that there is reason to believe that it will, in time, compare favorably with the other remarkable features of Catholic missions.

THE RIGHT REVEREND MONSIGNOR JOHN J. BURKE, C.S.P.

Many will be the well-deserved praises spoken and written of the Right Reverend Monsignor John J. Burke, C.S.P., to whom death came so suddenly on October 13 at his home at the National Catholic Social Service School here in Washington.

How broad his outlook on life was may be gathered from the fact that although General Secretary of the National Catholic Welfare Conference, heavily burdened with religious and social problems of the country, he had time to listen to my plea for medical care for the women of far-off India, and, what is more, he was actually interested to the point of thinking of ways and means for its promotion.

When the Society was formally started, Monsignor Burke was one of the few priests who encouraged us by his presence. Shortly afterward, he graciously consented to give us a spiritual conference which I have never forgotten. The text he chose was "Give and it shall be given to you: good measure and pressed down and shaken together and running over shall they give into your bosom. . . ." Luke VI, 38. The conference was so beautiful that the main points of the exhortation were entered in our chronicle: great personal fidelity to Our Lord; generously aiming at the highest, looking at the peak, filling the jar to the brim; trusting in God's willingness to help us; putting our hand in His!

It seems to me that unconsciously Monsignor Burke expressed, in the ideals he put before us, his own program of life. As I saw him lying in state, so serenely at rest, the text of this sermon came vividly to my mind and I felt convinced that he had lived what he had preached.

Requiescat in Pace!

ANNA DENGEL, S.C.M.M.

GENERAL INTENTION OF THE APOSTLESHIP OF PRAYER FOR DECEMBER: Complete success of the Eucharistic Congress in the Philippines.

MISSION INTENTION: That converts in mission lands may contribute to the support of the Church.

Book Reviews and Review of Reviews

ZEITSCHRIFT FÜR MISSIONSWISSENSCHAFT. Prof. Dr. J. Schmidlin. Münster, October and December, 1936.

The first article in the October number is short but significant. It is a study of "Education and Science in the Late Middle Ages" and an attempt to assemble the scattered and much-neglected data on this topic. The missionaries of these countries, living in a time when books were few and unbelievably precious, yet succeeded in acquiring a reputation for being scholars and expert teachers. The example of Raymond Lully in the Arab missions and Frater Johanca's work for the Tartars show that these eminent mission scientists placed emphasis on the intellectual part of mission work. Both insisted that there was room for the very best of western intellects in the ranks of their missionaries, in order to gain a foothold among the educated.

"The First Dominicans in India" is of historical as well as missionary interest. The first Portuguese Dominicans reached India in the early part of the sixteenth century.

In those days, in order to do mission work, it was considered necessary to live outside the Order, for which a special dispensation was given. Convents and community life were obviously impossible. Of necessity, therefore, the history of the first Dominicans in India is a series of biographies. At the earliest possible date, however, the Dominicans reverted to their original custom and monasteries were built in several cities.

In the December issue of the Z. M. we find the "Missions of Oceania" in the limelight. The first article describes the present status of this extensive mission field thoroughly and comprehensively. In a short historical review the author explains the slow and painful growth of the Catholic Church in these numerous islands scattered over the Pacific Ocean. The missionaries found their first point of contact with the natives in the tobacco-trade, which served to pave the way for the preaching of the Gospel. Besides the usual methods of catechism, baptisms and administration of the Sacraments, the heroic example of the martyrs in Oceania was a most powerful means which drew pagans to Christianity. Later organized social, education and charitable institutions were established. More recently still the press, art and the modern developments of science have been employed by the missionaries.

In close connection with this article is the study of Dr. Schmidlin's on the "Mission-Methods of the First Missionaries to Oceania," which confirms, in every respect, the observations and conclusions of the first author.

From the pen of an active missionary in China, Father Albert Czech, S.V.D., comes a remarkable discussion of "The Mission Work of the Church as a Proof of Its Catholicity." Working in a country where there are as yet but six Catholics to 1,000 inhabitants and where the social and political influence of Catholics is almost nil, Father Czech has felt the power of the Divine origin of the Catholic Church which enables it to unite among its faithful numerous strange and utterly different nations, without destroying any of their native characteristics, nor losing its identity as the Church of Christ.

Among the shorter articles are found: A discussion of the missionary activities in the home countries; statistics of the African and Indian Missions, the decision of Propaganda on the Oriental Rites and a report on the mission courses and congresses of the past year.

From the pen of Dr. Schmidlin appears a review of "Missions and Charity," by Dr. Berg, which was the topic chosen by the Society for the Propagation of the Faith for the study program of 1935-1936. Then follows a survey of missionary progress in India and Oceania and the usual book reviews.

IL PENSIERO MISSIONARIO. Edited by the Missionary Union of the Clergy. Rome, July, 1936.

The first half of this issue is taken up with the publication of and comment on the "Instruction of the Propaganda Fide to the Apostolic Delegate to Japan on the Duties of Catholics Towards Their Country." In recent years the matter of Confucian worship in schools, presence of Catholics in the temples and at funerals, national religious feast-days and various allied problems had come to a head and demanded official solution. After careful study, the Sacred Congregation has decided which of these acts are purely nationalistic and could be permitted and which are obviously of a non-Christian character and as such forbidden for Catholics.

Two short articles follow, one on "Religious Societies in Islam" and the other a study of "Missionary Preaching." Under the biographies, this time, appears the life story of Constant Lievens, S.J., the apostle of Chota Nagpur. A number of book reviews completes this issue.

INTERESTING ARTICLES IN FOREIGN MAGAZINES

"Die Katholischen Missionen," October, 1936.

This number of "Die Katholischen Missionen" deals almost exclusively with the peoples, habits and mission activities in East Asia, particularly Mongolia and Tibet. The history of the people, with their native customs and beliefs, is carefully studied and described in a most interesting, comprehensive and vivid manner. The series of five well-planned articles concludes with an impressive picture of the world-wide activity and effect of Catholic missions.

"Nos centres d'aide médicale indigenè au Katanga," by a Benedictine nun in "Le Bulletin des Missions," August, 1936.

A Benedictine nun, from her post in a bush hospital in Katanga, Africa, established by her order in 1928, gives a description of the field of labor and the methods of coping with the problems presented. The Sister enumerates the bush hospitals which have been established in this region and includes an account of occurrence and treatment of prevalent diseases, especially yaws, tropical fevers and eye affections.

"Zeitgemässe Aufgaben des Laienapostolats in den Missionen," by Prof. Dr. Max Bierbaum, in "Die Katholischen Missionen," November, 1936.

According to Dr. Bierbaum, the lack of an interested and active lay apostolate is an important reason why the Catholic Faith has not yet become a factor of power and importance in many foreign mission countries. Constructively, he proposes a plan of organized "Catholic Action" for such countries.

"LeVillage Indien," by His Excellency Msgr. Louis Gayet, M.S.F. S., Bishop of Nagpur, in "Les Missions Catholiques," October 1, 1936.

His Excellency gives a graphic description of social and political systems in isolated Indian villages, systems which have existed since 600 B.C. with very little change. The value of realizing this state of affairs can be gauged from the estimate that of India's 352,000,000 inhabitants, 315,000,000 live in villages.

"Der Eucharistische Kongress 1937 *in Missionarischer Hinsicht,"* by J. Peters, in "Die Katholischen Missionen," November, 1936.

The significance of the Eucharistic Congress for the Philippine Islands and the Orient in general is treated in this article from a missionary point of view. The number of Catholics in the Philippines is greater than of all Asia, yet the number of priests is comparatively small. The author suggests that under the impetus of this religious demonstration the Philippines might well become the central point from which an active apostolate might radiate throughout the Orient.

ROME HAS SPOKEN!

"It has always been the practice of this Sacred Congregation to have the methods of the apostolate conform to the varying needs of time and place. . . . This Sacred Congregation would like to see new religious institutes for women founded who will dedicate themselves principally to health work, making due provision for necessary safeguards. . . . These new duties demand a proper technical and spiritual preparation. The Sisters should obtain certificates as doctors and nurses . . ." (From the Decree of the Sacred Congregation of Propaganda Fide.)

OUR PART!

Rome's wish is Rome's command for us. We must go forward with greater energy, courage and confidence. Our most urgent need is a larger house where our young Sisters may prepare for their life's work as Medical Missionaries in India and other mission fields.

YOUR PART!

Become a partner with us in our work by your Investment in our MOTHERHOUSE FUND!

The Society of Catholic Medical Missionaries

The Society is a COMMUNITY of Sisters—doctors and nurses, who devote themselves to the care of the sick in mission countries.

Scope of the Work

The work extends to hospitals and dispensaries, medical schools and training schools for nurses, welfare centers, leper asylums, traveling dispensaries; also to visiting the sick in their homes. It affords an abundance of opportunities to combine the spiritual and corporal works of mercy.

Fields of Labor

The Society was founded for the purpose of sending qualified Sisters to India, China, Africa, and other mission countries.

Rawalpindi

At present the Society conducts a hospital for women and children in Rawalpindi, in the Mill Hill Prefecture Apostolic of Kashmir and Kafristan, India. Here, the majority of Mohammedan and Hindu women are still secluded and therefore can avail themselves only of medical aid given by women. From its beginning, this hospital has given training courses for Indian nurses in order to meet this need.

Dacca

In the Holy Cross Mission of Dacca, Bengal, members of the Society are entrusted with the nursing in the Mitford Hospital and the training school for Indian nurses. In the same city, they are in charge of two maternity and child welfare centers where they train native dhais for this work. They also make house-to-house visits for the care of the sick and the instruction of mothers.

The Sisters give classes in hygiene and home nursing in some of the schools of Dacca; also to groups of Indian women.

Requests to undertake work for the sick have been received from many mission bishops, thus showing the great need of vocations.

Requirements for Admission

The requirements for admission are:

1. A sincere desire to give oneself to God in the mission field.
2. Good health.

The age limit is 30 years.

The Society undertakes in suitable cases to provide the necessary education for all those who have not completed their studies for the medical or nursing profession. The scope of the work also calls for a large number who do not wish to do medical work directly. These do the non-medical work connected with every institution at home and in the missions.

For further information, apply to:

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